State of Montana
Department of Public Health and Human Services
Human and Community Services Division
Early Childhood Services Bureau
http://www.bestbeginnings.mt.gov

DPHHS-HCS/CC-152
(Revised 12/11)

Best Beginnings
Child Care Scholarship Program

CHILD HOUSEHOLD MEMBER INFORMATION FORM

- ONE PER CHILD -

CCR&R ELIGIBILITY SPECIALIST STAFF ONLY	
CASE / CASE EVENT NUMBER	
HEAD OF HOUSEHOLD NAME	
ELIGIBILITY BEGIN DATE	ELIGIBILITY END DATE
ELIGIBILITY DETERMINATION DATE	R&R DATE STAMP
CASE EVENT WORKER NAME	

GENERAL PERSON INFORMATION

GENDER: ☐ Female ☐ Male	Ethnic Affinity? (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino		
LAST NAME	FIRST NAME	MIDDLE NAME	
BIRTH DATE	AGE	SOCIAL SECURITY NUMBER (*optional*)	Montana State Resident: ☐ Yes ☐ No
US CITIZEN: If this is a child who needs care, is the child a US Citizen? ☐ Yes ☐ No			
RACE: ☐ Asian ☐ Black or African American ☐ Caucasian/White ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Alaskan Native			Tribal Affiliation? ☐ Yes ☐ No Tribe _____
Applicant (Head of Household) Name		Relationship to Applicant	

SPECIAL NEEDS

Does this child have special needs or are you concerned about special needs? ☐ Yes ☐ No
If Yes, please talk more with your Eligibility Specialist regarding additional services for children with special needs.

SCHOOL

Does this child attend school (including preschool or kindergarten)? ☐ Yes ☐ No If Yes, please complete the below information		
This child: Is currently in the _____ Grade or will be in the _____ Grade (in the Fall).		
School Name	First day of school?	Last day of school?

DAYS AND TIMES STUDENT ATTENDS SCHOOL

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day

Workers Initials _____ Date _____

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Child Household Member Name	Applicant Name

CHILD SUPPORT

Does this child have a parent who does not live in the home? ☐ Yes ☐ No

Families with a parent absent from the household must comply with the Child Support Enforcement Division or must receive child support under a court order.

- Please mark below how you meet the requirements for Child Support Compliance!

☐ Cooperation with CSED	CSED Case #	Who is child support received from?	Amount per month?
☐ Court Approved Parenting Plan		Who is child support received from?	Amount per month?

☐ Claim Good Cause (*please see good cause form*)

Please indicate what state or tribe do you co-operate with?

SHARED CUSTODY / VISITATION SCHEDULE

If your child spends time with his or her other parent, please describe the schedule or shared custody arrangements, by indicating the time and day that the child is with you under either a shared custody or visitation agreement.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day

If schedule varies please explain

CHILD CARE PROVIDERS

- PLEASE list all providers that you have for this child
- A Child Care Service Plan needs to be completed for each provider that your family has and must include each child's schedule, for when they are in care.

PROVIDER #1	
PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER
PROVIDER'S ADDRESS	PROVIDER'S LICENSE NUMBER **PV#**
PROVIDER #2	
PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER
PROVIDER'S ADDRESS	PROVIDER'S LICENSE NUMBER **PV#**
PROVIDER #3	
PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER
PROVIDER'S ADDRESS	PROVIDER'S LICENSE NUMBER **PV#**

Workers Initials _____ Date _____